



HONOURING LIVES: FINAL REPORT

March, 2019

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This report was prepared by:

Marie Laing

Michelle Firestone

&

Jessica Syrette of

Well Living House

In partnership with:

Steve Teekens and the staff of

Native Men's Residence

Harvey Manning and Leslie Saunders of

Anishnawbe Health Toronto

Traditional Knowledge Holders and Community Members

Jacqui Lavalley and Ed Bennett

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Feedback on this report is welcome, and can be addressed to Dr. Michelle Firestone (firestonem@smh.ca) and Jessica Syrette (syrettej@smh.ca).

Introduction

In the context of socio-economic deprivation, persistent impacts of historic trauma, and ongoing colonial violence, Indigenous people suffer from elevated burdens of mental health disorders and substance misuse. With over 70% of the Indigenous population living in urban settings in Ontario, ongoing disparities in social determinants of health such as income insecurity, unemployment, food insecurity and inadequate housing are exacerbated with urban residence. Studies like the Toronto Aboriginal Research Project (TARP)¹ have highlighted a number of issues that contribute to homelessness among Indigenous people in the city including addictions and substance use, a lack of affordable housing, challenges with accessible transportation, racism and lateral violence.

For a number of years, health and social service agencies in Toronto have been reporting an unprecedented rise in the number of deaths among people who are homeless and vulnerably housed. In response, Toronto Public Health has been tracking homeless deaths since 2017 to generate a more accurate estimate of the number of deaths and to gain a better understanding of the causes of death.² To date, these data do not report on Indigenous identity. Likewise, Indigenous people have been absent from the Coroner's death investigations of people experiencing homelessness. However, some service organizations have been undertaking their own research into premature deaths in the Indigenous community. In one study, collaborating health and social service organizations serving the Indigenous community in Toronto reported that the average age of death among their clients was 37 years, compared to 75 years for the average Torontonian, and found that the cause of death was tied directly to issues arising from homelessness, physical abuse, and/or substance use, and existing chronic health conditions.³

In February 2017, Na-Me-Res and Well Living House acquired funding for a larger 2-year process evaluation project focused on the *Mino Kaanjigoowin Program*, a client-centred, integrated, culture-based and holistic program that is responding to the complex health and social needs of Indigenous men in Toronto (for a full description of this project and results, see: www.nameres.org and www.welllivinghouse.com). A parallel pilot study of 5 'social/verbal' autopsies called Honouring Lives was also conducted during this time. This report presents the innovative and unique methods utilized in the Honouring Lives pilot project, as well as the project findings.

The aim of this project was to explore the root causes and contexts surrounding the increasing number of premature and preventable deaths in the Toronto Indigenous community, as well as the impact of the ripple effects experienced by family, friends and a community of staff across the city. The project also identified gaps in the current systems of care and support services for Indigenous people and examined the resources available to those at-risk that might be contributing factors or producing unintended consequences. Ultimately, this has facilitated the identification of collaborative strategies as well as policy and advocacy efforts that can prevent future deaths.

Methods

Governance and Research Approach

Using a community-partnered approach, the Well Living House (WLH) led a mixed methods social/verbal autopsy pilot study. This approach built on established methods of community partnered Indigenous health research at WLH^{4,5} that aligns with wise practices for conducting Indigenous health research.⁶⁻⁹

The WLH upholds Indigenous ethical standards^{10, 11} that ensure balanced relationships between Indigenous and community partners and academics throughout the research process. The project was co-governed by Na-Me-Res and WLH through an established Memorandum of Understanding and an Honouring Lives advisory group consisting of Na-Me-Res and Anishnawbe Health Toronto staff, Well Living House research team members, as well as two community Elders.

Subject Selection & Participant Recruitment

Throughout this report, we refer to the five people who are the focus of this project as ‘subjects’ and the 26 people we interviewed about their lives as both ‘participants’ and ‘key informants.’

Social/verbal autopsy subjects were selected by staff at Na-Me-Res and Anishnawbe Health Toronto based on their knowledge of Toronto’s urban Indigenous community. All subjects died no longer than 3 years (May 2014) and 3 months (May 2017) prior to commencement of the study. Five subjects were initially selected who would represent the diversity of Toronto’s Indigenous homeless population. Researchers were unable to recruit an adequate number of participants for one of the initially selected community members, and they were removed from the study. Another community member was selected in their place with the help of the same community partners and team.

For each of the five subjects, between five and six interviews were conducted with key informants (friends, family members, and health and social service providers) who knew them and the circumstances surrounding their deaths. Service providers included current or former staff from 5 different health and social service agencies in Toronto.

Participants (n=26) were selected through purposeful sampling. These key informants represent just some parts of the networks of care, support, and community in which the five subjects were embedded. Staff at Na-Me-Res and Anishnawbe Health Toronto identified and provided information to potential participants and then connected them with the research team for interviews.

Data Collection

Interviews were conducted using a mixed method tool that included both open- and closed-ended questions relating to the events and circumstances surrounding each death. Closed-ended questions were asked using a survey questionnaire. Open-ended questions allowed respondents to tell their story through a narrative approach, while closed-ended questions helped to provide a more complete chronological inventory of signs, symptoms and possible causes of death.

The mixed method tool was developed based on from previous work of Anishnawbe Health Toronto,³ existing instruments developed by the World Health Organization,¹² and a tool used in a social autopsy of deaths among homeless people in Ottawa.¹³ Interviews were between 30 and 60 minutes in length, and were audio recorded and professionally transcribed. All participants were offered an honorarium for their time.

Analysis

This report details the qualitative findings of this study through thematic analysis of interview transcripts, and does not outline the quantitative data collected through survey questionnaires.

The narratives shared by the key informants were analyzed through a critical decolonizing lens that examines ongoing power structures and social systems driving marginalization of Indigenous peoples, while at the same time striving to honour the strengths and complexity of Indigenous communities.¹⁴⁻¹⁷ Transcripts were thematically analyzed using an iterative coding process by three members of the research team. The first stage was open coding, in which each transcript was read and manually coded by two separate team members, developing codes inductively. Research team members then met to reconcile codes and group them into themes. Cross-participant themes were identified and compiled by the research team, and meaningful quotes were extracted from transcripts.

The research team then conducted a second-stage narrative analysis. The narrative analysis of the interview transcripts was completed on a subject-by-subject basis to develop a “lifeline” mapping each subject’s life from childhood to death. Using the information available in the interview transcripts, these lifelines tracked significant events including family separation and apprehension by child welfare agencies, significant personal relationships, instances of violence, incarceration, hospitalizations, and substance use patterns, as well as contextual data on significant deaths and losses in subjects’ street community. Lifelines also included a list of the personality descriptors and strengths of each subject as a visual reminder of their complex personhood. This method of narrative analysis allowed the research team to identify relationships between health outcomes and contextual factors such as housing, substance use, and community-level grief on a chronological basis for each subject, providing richer understandings of the events leading up to their deaths.

As part of the project governance structure, preliminary results were presented to the advisory group for feedback at two meetings during the analysis process; detailed lifelines for two subjects were presented at the first, and cross-participant themes and participant recommendations were presented at the second.

Description of Sample

Subjects were all Indigenous community members who had been living in Toronto for several years, although most were born and grew up elsewhere. All had experienced homelessness at various points throughout their life, all were survivors of violence, and all accessed services at one or more health and

social service organization in Toronto. Importantly, all five subjects were valued members of their communities, and are deeply missed.

The following quotes illustrate just a few of the ways in which key informants remembered each subject. All names are pseudonyms.

Justin was a well-loved young man. He grew up in Toronto and was well-connected to his community, with a wide network of friends. He built strong bonds and sought out connection with friends and their parents as a support system, with many friends' mothers describing him as being like an adopted son. Thoughtful and well-spoken, he was recognized as a leader in his community, and participated in ceremony and cultural events. Throughout his life, Justin supported his friends, family, and community with humour and kindness. His young daughter was his world, and he often spoke about his desire to be present in her life. He is remembered as being quick to defend his friends and loyal to his loved ones.

“He was pretty funny. Like you know. He was the... what do you call... the joking one of the group. Like you know, he would joke around and always make fun of you, but not like, meanly but like you know, just make fun of you.” — Key Informant

John was well-known in downtown Toronto by health care workers, social workers, Indigenous community members and the general public. He is described as being loud and rambunctious. He would speak up about what he was thinking and was self-reflective about the stereotypes imposed upon him. Often using humour as a way to disarm people and subvert expectations, people knew him as very expressive. Always original, he is remembered fondly for his many creative and artistic talents. One worker told a story of him carefully insisting that she not drink during her pregnancy; she said that in that moment, she could feel his love and how much he wanted to care for the next generation.

“He’s in my, like my heart and he’s always going to be missed. And I’ll remember him for all the fun times we had even the bad times that we went through and [...] he was a kind, caring, sharing person that had my respect and always will. I mean I know there was other people in this community that can say the same thing and he is going to be missed and he still is being missed.” — Key Informant

Robert loved to be around the people he cared about. He was well-acquainted with the services and supports available in the city of Toronto, often sharing this knowledge with his peers. Described as strong, resilient, and highly resourceful, Robert coped during tough times by using his sense of humour and spending time with his community. His street family, his partner, and some trusted service providers were main sources of support, and he was impacted by the upsurge of deaths in Toronto’s Indigenous street community over the months preceding his passing. Friends spoke of his tenacity, intelligence, and his love of music. He was very proud of his young son, and wanted to be involved in his life.

“He was proud of who he was and how smart he was and that was great [...] he was open to learning [...] he was very smart with music. He knew a lot about music and bands and stuff like that.” — Key Informant

Gordon was a generous and hardworking older man. He loved his family and deeply valued his community, and built close relationships with the Indigenous health organizations that best suited him. Many spoke of his love of people, and how his desire to be with his friends would often trump all other concerns. He was described as being very active in his younger years, riding a bike around the city, running, swimming, and going for long walks. Gordon was a skilled tradesperson and was proud of his achievements. He was also an avid learner; workers described how he loved to challenge himself, pursuing a wide variety of interests and educational opportunities. He is remembered for his kind and calm demeanor, and how he often encouraged those around him to take it easy.

“You know, I’d get him off the street, bring him on home, let him cook, you know, let him eat. He’d always bring us stuff. Like always, you know, he’d always say, ‘Oh, let’s go get some eggs, [name],’ ‘you want to go get some bread,’ whatever you know, ‘You got coffee? What? You got no cream, I’ll go.’ You know, he’d stay for a couple of weeks and he would clean my house. I’d wake up to the smell of like cleaner and you know, coffee and eggs. And you know, he would bring me coffee in the morning. That’s the kind of person he was.” — Key Informant

Melissa was a bright young woman. She was described by those who knew her as fiercely loyal and protective of her friends, often speaking out against injustice and expressing pride in her street family. They described her as an integral part of their lives, always telling stories and keeping their days upbeat. She was drawn to the outdoors and would often encourage her friends to pass time in parks rather than alleyways. When her group would hesitate, fearing discrimination from police and neighbourhood passersby, she would remind them that they deserved to be outside, to sit in the grass, to occupy space and to enjoy the sunshine. Friends spoke of her incredible beauty and her kindness. Workers spoke of her thoughtfulness and intelligence, and expressed their belief that she had the potential to make it off of the streets.

“She was always somebody outspoken, very opinionated, she could be very stubborn, but such a go-getter. I describe her as a bit of a s’more, so like she might seem sort of like rough and abrasive on the outside, but on the inside, she was just so soft and very tender.” — Key Informant

Findings: Themes & Context

Colonization

At the core, the causes of death for all five subjects can be traced to historical and ongoing practices of colonization.

The deadly impacts of colonization in the form of infectious disease, forced relocations, and residential schooling are well-known.^{18, 19} However, it is not only the lasting impacts of these historical practices and policies that lead to negative health outcomes for Indigenous communities. Colonial violence is ongoing for Indigenous communities in the form of child apprehension,²⁰ mass incarceration,²¹ and ongoing displacement from lands and waters,^{22, 23} and all of these government practices had profound impacts on the lives and premature deaths of the five subjects. The most prominent links between colonial practices and the deaths of subjects were through the separations of Indigenous children from family, community, and land, and the intergenerational impacts of such separations.

Government policies such as residential schools were intended to prevent the passage of cultural knowledge from one generation to the next and sever relationships to territory, thereby undermining the health of Indigenous communities in order to minimize political resistance to ongoing land theft.^{19, 20} Subsequent government initiatives such as the Sixties Scoop and current policies of child apprehension continue to advance these aims of dislocation, assimilation and community fragmentation.²⁰ As confirmed by a growing body of research,^{3, 4, 20, 24–26} the health impacts of these policies stem not only from the direct physical violence that residential school survivors and adoptees experienced while in State care (and sometimes subsequently re-enacted in their own families and communities) but also from the strategies used to cope with the trauma of disconnection, such as alcohol and substance use.

One subject whose story illustrates the ongoing nature of colonial violence perpetrated by the Canadian state is Gordon.

Gordon was apprehended and removed from his home community in Northern Ontario at age 2, along with his sister and brother. He and his sister were adopted by a family in an Indigenous community in southern Ontario, and his brother was adopted by another family in that same community.

One family member shared her understanding of the child apprehension policies that fractured their family:

“My reserve was totally without children and so I know that they were taken out into residential schools, placed in foster care and apprehended in some way. So that was meant to systemically annihilate our people.” — Key Informant

Colonial violence, in the form of child apprehension, had devastating impacts in Gordon’s life. Disconnected from his family, his home community, and his language, Gordon also carried the hurt of believing that his biological family simply didn’t want him, as he did not learn about the

Sixties Scoop until later in his adult life. Surviving physical abuse in his adoptive family, he began using alcohol to cope as a teenager, which contributed to his becoming, and remaining, homeless. He used ceremony and connection to his Indigenous community in Toronto as supports.

“[Gordon] liked the idea of being with the land, but never had that opportunity to go home and that’s I think that really hurt him a lot, is not really having any place. He had no sense of belonging anywhere and security and you know, like all the things that we need.” — Key Informant

The disconnection from family, community, culture, and land that underpinned each subject’s story is typified by the above quote. Without a sense of belonging or security, or the cultural supports to deal with this profound disconnection, Gordon coped by drinking. It was this coping mechanism that led to his death, from liver failure.

When asked about how Gordon’s death could have been prevented, two service providers directly named child apprehension as a root cause:

“The long-term measures would be how about if he had never been taken away from his family to begin with. How about that? And how about if he had always had access to his biological family and how about if anybody involved in the care to him remained in contact with them.” — Key Informant

“Yes, this kind of premature death is preventable. I don’t know the answer to it but I know that we’re responsible to change it. I don’t feel like there was any other outcome in a situation the way the system currently exists. When I think of [Gordon] I see a little boy [...] a little boy that was ripped from his community and never repaired and did his best to find the ways that he could find things that worked to cope.” — Key Informant

These participants clearly highlight the direct linkage between Gordon’s disconnection from his family and his premature death.

The impacts of colonization are felt at the individual, family, and community level. In their search to repair the damage caused by colonialism, many subjects built relationships with Indigenous community here in Toronto. However, subjects consistently faced barriers to accessing their support systems that were often, in one form or another, put in place by the same government that instigated the trauma of family disruption in the first place. Because of what one key informant called the “decimation” of traditional cultural supports, as well as the high incidence of trauma and grief within Indigenous communities, the limited cultural supports that are available are often either overburdened or perceived as such, leading to individuals choosing to use less healthy coping mechanisms. One participant shared how a client explained this decision-making process:

“The way they articulated it is because since the Truth and Reconciliation thing all these people are coming forward with kind of childhood sexual abuse from residential school and so all the Elders they

know are overwhelmed with that. And so then they're like, 'Well, at least I didn't deal with that.' It's just almost, it's like... and so I'm not going to take up an Elder's time." — Key Informant

This quote suggests that the combined impacts of high levels of community trauma and loss of traditional cultural supports stemming from colonization result in some individuals choosing not to engage in the few supports that are available, for fear of being a burden on community resources.

Outside of the internal impacts of colonization on subjects' relationships, sense of community belonging and self-worth, the ongoing structural racism embedded in Canadian society and the everyday prejudices of Canadians had deep impacts on all subjects' well-being. Through systemic racism in policing, the criminal justice system, health care, and child welfare, and the ongoing displacement of Indigenous communities, the Canadian state at times actively worked against subjects as they attempted to break the cycle of addiction and trauma.

Family Disruption, Child Apprehension & Trauma Re-Enactment

Though child apprehensions and their intergenerational effects were a symptom of ongoing colonialism in subjects' lives, these family disruptions had such deep impacts that they emerged as a distinct theme in the data. For each subject, disruptions of their early family life had profound impacts on their health, sense of self-worth, and the ways in which they coped with challenges. Like Gordon, most subjects were apprehended by a child welfare agency and subsequently adopted or placed in foster care or group homes as children. Their experiences align with the well-documented targeting of Indigenous families by child welfare agencies; according to 2016 census data, while Indigenous children make up just 7.7% of children in Canada, they account for over 50% of the children in foster care.²⁷

For some subjects, their families were disrupted even before the colonial incursion of child welfare agencies during their own childhoods, by abuse and neglect passed down through generations. One participant linked the lack of parenting skills that led to these behaviours directly to intergenerational trauma:

"We needed older role models that posed no risk to our freedoms and choices, who could have influenced us with kindness and resources with no strings attached [...] [Melissa] ended up on the streets because that is a logical consequence of growing up feeling like you are an ugly and unwanted kid whose needs don't matter and come second to the party. I know that is how she felt because she told me. Trauma re-enactment is a bitch." — Key Informant

Here, this participant highlights the importance of stable caregivers in the lives of children and the devastating impacts that growing up without security and self-esteem had for Melissa, eventually leading to her living on the streets. Importantly, this participant also clearly links the trauma that Melissa's parents experienced (including, for one parent, being a survivor of the Sixties Scoop) with their treatment of Melissa. This passing of trauma from one generation to the next, and subsequent cycles of child apprehension and recurrent trauma, are also documented throughout the literature.^{20, 28}

This “trauma re-enactment” was a shared theme in some subjects’ stories, while other subjects were taken away from loving and supportive families with disastrous effects:

“They haven’t lived lives where they’ve had... they’ve received enough love from enough sources to teach them and to tell them they need to love themselves and to take care of themselves. So why does that happen? Because people get separated from the people that actually love them, you know, they’re put into circumstances like foster homes or adopted families where they’re not, you know, they’re not necessarily in that place yet. Just because it’s called a family doesn’t mean that there are people that care about you and take care of you and teach you to love yourself and take care of yourself. You know, sometimes we learn those things late in our lives and sometimes too late.” — Key Informant

This participant calls attention to the lack of self-care and self-love skills that was common among subjects, linking it to the lack of supportive caregivers to teach them these skills as children. As a result of not having these skills modeled by their families, nor by adoptive or foster families, subjects struggled to meet their basic needs while working through the trauma of dislocation with limited resources.

Compounding this sense of dislocation was the often traumatic nature of subjects’ apprehensions by child welfare agencies. One friend described Justin’s apprehension, which occurred at their elementary school:

“The CAS had come to the school to come pick him up to just take him because he wasn’t... his mom lost him whatever. And it was crazy because when I see... I just heard a bunch of like freaking out and throwing chairs and like he was just freaking out.” — Key Informant

This description suggests that Justin experienced his apprehension as traumatic. Even for those subjects whose apprehensions were non-violent, the combined weight of separation from their families, communities, language, and traditional territories was a trauma with which they coped for the rest of their lives. In several cases, the adoptive homes or group homes where subjects were sent were places they experienced abuse and violence.

It is worth noting that in the cases of several subjects, the continued threat of child apprehension limited their ability to be present in their siblings’, nieces’, and nephews’ lives when they were actively using substances. For these subjects, child apprehension was not only a past trauma that haunted them, but was also a direct and continual impediment to their ability to give and receive support within their families, thereby creating an additional barrier to healthy coping.

These negative impacts of child apprehension on individual, family, and community health and well-being — and the devastating effects of intergenerational trauma passed from survivors of residential schools and the Sixties Scoop — are also well-documented in the literature.^{4, 20, 24, 26, 28} Further, the links between involvement in the child welfare system and subsequent experiences of homelessness for Indigenous people in Toronto have also been empirically demonstrated;^{1, 29, 30} the City of Toronto’s 2018 Street Needs Assessment found that 37% of Indigenous respondents had spent time in foster care.³¹ These figures, along with participant reflections, make clear the coupling of disconnection from family, community, land and culture and the subsequent struggle to meet one’s needs.

Building Chosen Families

After having their families disrupted by child apprehension or by intergenerational cycles of trauma and violence, subjects all built their own chosen family as adults in order to meet their needs of safety, support, and belonging. This desire to build supportive relationships and community was a major strength, and was a driving force in several subjects' lives.

This was especially true for Justin, who demonstrated a great deal of resiliency through building strong relationships with friends and their families after being separated from his birth family. This need for a secure family was also expressed in his love for his daughter. His dedication to providing for her and supporting her were complicated by his break-up with her mother, and this second family separation took a heavy toll on him:

“That’s when I started seeing him spiraling down because [...] his baby mother, like wouldn’t let him see his daughter and that’s when I started seeing... that’s when I started seeing him spiraling down but then like... he got that place to actually see her, like you know [...] I think that’s when he started spiraling down.” — Key Informant

This key informant describes Justin’s “spiraling” into alcohol and substance use after yet another significant disruption in his family life. Though he secured housing in order to be able to have his daughter visit him, the building in which he was housed was not conducive to managing his addictions, creating yet another barrier to stability.

Violence & Trauma

In the lives of all five subjects, experiences of violence — whether as the victim, the perpetrator, or a witness — were commonplace. For many, violence began in childhood: two of the five subjects survived physical abuse as children, with one more subject having disclosed unspecified (suggested either physical or sexual) abuse as a child. Further, the majority of subjects were survivors of sexual violence — beginning in childhood for three subjects, with two subjects surviving sexual violence as adults as well. These early traumas had deep impacts on the remainder of subjects' lives.

Speaking about Melissa’s experiences of neglect and abuse in childhood, a loved one shared:

“She learned early on that she was worthless and she didn’t know how to undo that hurt.” — Key Informant

The violence this subject experienced in her early life significantly impeded her sense of self-worth; since she was not provided the space or resources to heal from the violence, the effects lingered and were compounded through her adult life. Another participant shared a similar reflection about John:

“I think that’s where the drinking came in. I believe that the drinking was like — I know we all know that substance use is never around the substance, but I felt that there was — because he felt everything so intensely, you could see that there was this huge pain that he was carrying around that never got addressed in any shape or form.” — Key Informant

As with many subjects, John did not have the opportunity to learn healthy coping skills from his family in childhood, likely due to the intergenerational impacts of colonization. He dealt with his trauma by using alcohol in the absence of healthier coping mechanisms — a common pattern among families and communities impacted by residential schools and the Sixties Scoop.³²

The lingering impacts of childhood trauma were evident in the lives of all subjects; these impacts were further compounded by the ongoing violence of street life. Incidents described by participants are too numerous to include here, from subjects witnessing friends’ murders to one being sexually assaulted by his own street family.

All subjects also experienced interpersonal violence and physical fights within their communities. Participants described links between alcohol use and engagement in violent behaviour for all five subjects and their peers. Intimate partner violence was also a common experience, with three of five subjects either harming their partner, being harmed by their partner, or both. These experiences align with recent research that confirms upwards of 80% of Indigenous adults in Toronto have experienced household violence,³³ while 48% of Indigenous adults in Toronto have experienced at least one racially motivated verbal or physical attack in their lifetime.³⁴ Such patterns of violence in Indigenous families and communities are deeply linked to the intergenerational impacts of residential schools and related traumas.¹⁹

Institutional Violence

Importantly, violence also came from institutional sources for many subjects. Aside from the structural violence of being displaced from their families, languages and traditional territories by colonial forces, subjects often also faced physical violence from the state. For one subject, violence also came from forced psychiatric treatment. One friend described how being forcibly medicated impacted John:

“They had to give him the needle and that really wiped him out, the day of the needle. And sometimes he’d be like, “Ugg.” And sometimes they... they... they upped the dose of his medication and you could see the anger in his eyes and because he realized like, ‘Oh my god, they’re putting more shit in me right now and that just hurts me right now.’ Like it physically hurts him and he feels the pain and he doesn’t like... doesn’t really like, look forward to it but he knows if he doesn’t take it, he’d be in a psych ward or whatever.” — Key Informant

Faced with the prospect of being involuntarily hospitalized, John was coercively medicated. Many of John’s friends and service providers noted that the mental health treatment he received was solely medication, with no counseling or talk therapy provided. The lack of adequate mental health services experienced by participants is corroborated throughout the literature: lack of access to counseling has been noted as a significant barrier to healing for Indigenous survivors of violence,²⁶ and the need for

culturally-based mental health services was highlighted as a key issue by homeless participants in the TARP.¹

Notably, the majority of subjects were targeted, harassed, and beaten by police, which key informants said significantly undermined subjects' trust in and willingness to engage with the justice system.

One participant spoke about Gordon's frequent interactions with the police:

"When they felt like making an example out of him they would beat him." — Key Informant

Participants noted that often, subjects would not report police misconduct for fear of reprisal:

"My perception is when that kind of stuff happens, either people are just so busy kind of living day to day that they don't have space to kind of figure out how to get some sort of justice in that situation, or they feel really scared and terrified that if they do that it'll come back on them." — Key Informant

Neither the experience of discrimination at the hands of Toronto police, nor the fear of retribution for reporting police misconduct are uncommon among Indigenous people in Toronto.^{1,35} Nor was subjects' lack of faith in state mechanisms of redress unfounded: even when one subject reported being beaten by police and the lawsuit made it to trial, the officers who assaulted him were acquitted — which friends and service providers noted had a detrimental effect on the subject's mental health. Ongoing colonial violence and the subsequent denial of justice had a cumulative effect on all subjects.

Grief

Alongside violence, an ongoing trauma for almost all subjects was the constant grief caused by deaths among their friends and peers in the street community. This community-level grief caused by the recent upsurge in deaths on Toronto's streets was compounded by subjects' experiences of loss that are common to Indigenous communities across Turtle Island.

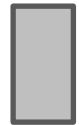
One incident shared by a participant about Melissa illustrates the struggle of grief when homeless:

"And I see [Melissa] out front just crying. Like kind of wailing essentially. So I said, 'What's up? What's going on?' And so you can see people walking by... 'Crazy woman,' ... like she's not crazy. And I said, 'What's up?' She's like, 'My like childhood friend just committed suicide.' And so of course she was bereaved right, so in that situation, just because I happened to be... and she had said 'I came here because I knew you guys were closed, but it just felt like home.' Right. So a locked door is your home, right." — Key Informant

As illustrated by this quote, the realities of homelessness — little privacy, access to social services limited by hours of operation, and derision from the public — made grieving very challenging for Melissa. Without proper culturally appropriate resources for grief, and without the privacy and security of a stable home, Melissa, like many subjects, turned to alcohol to cope.

As community-level grief was an ongoing trauma for many subjects, an unmet need identified by some key informants was the need for culturally appropriate grieving resources:

“For a lot of our Indigenous guys, the way the services are offered, it’s not very culturally appropriate. Even our services here, we’re constantly talking about that and we’re having a conversation there, like, even just the way they wanna deal with loss, you know, it’s not necessarily the way we wanna deal with loss. So I find a lot of them, when it’s a memorial service, it doesn’t click with them. Like, they won’t even sit in the same space. They’ll be drinking outside and they’ll be supporting each other because it’s something different that they need at that time. And their priorities, their understandings of certain concepts are very different than what like Toronto imposes on people.” — Key Informant



Here, it is prudent to note once again that subjects were part of reciprocal relationships of care and support; just as they were bereaved by losses in their communities, so too, do their deaths leave holes in the lives of those they left behind.

Resiliency & Resourcefulness

All subjects were extremely resourceful and resilient, using the coping strategies available to them and trying to make the best choices possible within a limited range of options. Many built networks of support for themselves through friends, chosen family, and service agencies — and in turn, they provided support for others. Several key informants described Melissa fiercely advocating for herself and her loved ones in the face of pervasive racism and discrimination:

“For example, she went through with lodging a complaint when the police came and... kind of around racist harassment in the park to a bunch of... her and a bunch of other people, that the drunken Indians need to get out of the park kind of stuff. So she kind of stood up for herself as well. Like, in that context and then also she’s pretty tough. Like in the context of people she hung out with. She definitely had like a kind of... kind of... most of the interactions with her she was quite kind of gentle and really... but she also stood up for herself.” — Key Informant

Not only did Melissa demonstrate toughness in everyday survival within her sometimes violent street family, she showed leadership and stood up for herself and her peers in the face of consistent police harassment.

All subjects were proud of their Indigenous heritage, with four of five accessing ceremony and cultural activities as supports. Many participants pointed out the high degree of knowledge subjects held on the services available to them within the city of Toronto. Several participants described Gordon’s ability to face repeated challenges:

“He had a very urban smart to him. And not smart even, that’s not even a good word. He had a very urban comfort with him. He was comfortable in environment. He kind of knew how it worked or understood how it worked or understood what was available to him and what he could do. So he didn’t walk around sweating it. He didn’t have that sense that he was sweating so whatever his challenges were, he didn’t show like he was sweating it.” — Key Informant

“He was a strong person. And he had resilience and he wanted to retain who he was and I loved that about that person, because he could, you know, he’s not going to change who he is to get what he needs. He wasn’t going to do that. And that’s amazing that a person won’t do that. You know, it’s integrity.” — Key Informant

These are just two examples of the resilience that all subjects demonstrated in managing the multiple challenges of ongoing colonial trauma, insecure housing, and systemic racism.

Housing

Indigenous people are vastly overrepresented in Toronto’s homeless population; though Indigenous peoples account for an estimated maximum of 2.5% of Toronto’s population, they make up 16% of the city’s homeless population.³¹ As demonstrated in the literature,^{36,37} Indigenous homelessness in the Canadian context is inextricably linked to processes of land dispossession, intergenerational trauma and systemic racism; high rates of Indigenous homelessness must be understood within the context of these symptoms of ongoing colonialism.

A core contributing factor to the premature deaths of all subjects was a consistent lack of safe and affordable housing. All five subjects experienced insecure housing from youth until their deaths. Though all five subjects accessed various types of housing services in the city, housing periods were generally short. Participants articulated a number of common barriers subjects faced when attempting to secure housing, including long wait lists for small, poor-quality units, racism from landlords, and the difficulty of finding housing with a partner.

“How do you try to narrate to the general public why it’s so hard for some people to get housing beyond... so I think a big piece of it is they just don’t. Because there’s so little in Toronto it’s... like it’s 1.1 percent vacancy rate, which is really low. And then none of it’s affordable, right? And then on top of that, someone like [John], he’s Indigenous so immediately when people see him, there’s that race piece. There’s the fact that having him show up sober to an appointment, which most landlords if you show not sober, they’re probably not going to give you the apartment. The waitlist is so long.” — Key Informant

Participants also articulated a number of barriers to subjects staying housed, including alcohol use, guest behaviour, conflicts with roommates, violence in their housing, neighbors’ substance use, and isolation from the street community. Notably, many of these barriers to finding and retaining housing — long waitlists, experiences of racism, unsafe housing options, and a demand for affordable and social housing units that outstrips supply — were articulated by homeless participants in the TARP.¹

“It’s hard to assume that you can jump from being on the street to like an actual apartment, right, especially when you came from the res. You don’t know what to do with yourself and you’re just being homeless and abused, right? It’s a common problem. And so when they finally do get into these places,

like it's this tiny little room that's not conducive to their mental health. So then they're retriggered and you know, they're not able to handle it and all of a sudden they miss an opportunity and lost an opportunity and so they get labeled as not, I don't know, not trying or not working hard enough to be able to keep the things that they've been given or whatever. And it's just kind of a constant cycle of being given chances, while those chances are really like... like just breadcrumbs and they're upset that they don't thrive off of these breadcrumbs." — Key Informant

As the above quote illustrates, the compounding of a myriad of barriers to accessing housing, and subsequently staying housed, create a cycle of false starts that many participants said wore subjects down and disheartened them over time. Many key informants articulated a need for more transition supports for individuals coming from the streets into permanent housing, along with more supportive housing, as well as affordable housing with Indigenous cultural supports — consistent recommendations in several studies on Toronto's Indigenous homeless population.^{1, 35}

During periods of homelessness, couch surfing (with siblings, friends, and partners) and sleeping outside were subjects' preferred ways of coping, with shelters often used only as a last resort. The lack of a safe and stable home in which to live had a profound impact on all subjects, rippling out to affect their ability to make and keep appointments, access health care, and plan for their futures.

Oftentimes, when subjects were housed, it was not in housing that met their mental health, addictions, or cultural needs. At the time of his death, one subject was housed in a rooming house complex downtown, but was often choosing to sleep outside because he felt unsafe in the building and had an ongoing conflict with his roommate, who also had complex mental health challenges. He brought up concerns about his roommate and the condition of the unit to several workers, who were unable to help him. Though the building in which this subject was housed was a supportive housing facility, there were not staff onsite 24/7, and he had neither the level of support, nor the level of privacy and safety, that he needed. Toronto's low vacancy rate and high cost of living meant that his option for housing was to live in the same room as another person with complex mental health needs and inadequate resources. He was murdered near his housing by his roommate.

"It was a matter of maintaining housing which is a challenge for a lot of our folks, 'cause the housing that is offered to them is usually sub-par. I wouldn't want it for myself, like, bedbugs, you know, people with other issues, people not well matched up. And supportive housing. So it's like a disregard for who has what issues. So a lot of conflict. So I know that was an issue even in his last housing that, like, he told me that that was the case before as well. Because it's like, if you can't get any peace and quiet at your place of residence, you're not gonna go home. You're not even gonna cons— and he— that was, like, his— one of his triggers— he never, he never called it 'home.' He would get really mad if you asked, like, 'Oh, are you gonna go home tonight?' He'd be like, 'That's not my home. It's just a place I sleep sometimes.' He didn't consider it a home." — Key Informant

Health Care

The health and well-being of Indigenous peoples is shaped both by ongoing processes of colonization and community resistance and resilience in the face of these processes.¹⁸ These twin factors were evident in the lives of all five subjects: their health care experiences were characterized by racism and discrimination at individual and systemic levels, and they responded by utilizing a variety of strategies to meet their needs. Subjects often did not have long-term health care, instead seeking care at drop-ins or Emergency Departments (EDs) — a finding consistent with existing data on homeless individuals' elevated rates of ED use in Toronto.^{1, 31} Although they utilized hospital EDs when necessary, most subjects tried to avoid hospitals because they had experienced racism from health care practitioners, security guards, and EMS personnel.

"It's hard to get any traction when you're just surviving. So then when she actually had legitimate health care needs it was really to convince her to go because they were just going to treat her like crap." — Key Informant

This reflection is consistent with findings from other research which demonstrate that for Indigenous people, past experiences of racism from health care providers are a deterrent to accessing future care.^{4, 18, 38, 39} While some subjects experienced adequate care in some hospital settings, multiple participants noted that the "trifecta" of being homeless, Indigenous, and using substances frequently resulted in substandard care:

"Just based on everything I've experienced, like with that whole group, I just find that if you present in a hospital and you identify as Aboriginal, you have substance use and you're homeless, it's almost like that's the trifecta ensuring that you're not... like if you have any other health concern outside of that, you're probably not going to be taken seriously." — Key Informant

"He wasn't receiving good treatment. He also might have been viewed by them as not being there for anything other than substance related, which is just never a good combination with those folks. Substance related, can't remember. Aboriginal man presenting. Like, who's actually at this point quite rude. It just... so yeah, no, he wasn't getting any treatment. He was just being... being held as they were probably not prioritizing him." — Key Informant

The experiences that key informants describe here are corroborated by other data showing that racism and discrimination from health care providers is an all-too-common experience for Indigenous people in Canada.^{4, 39-42} In particular, concurrent discrimination based both on Indigenous identity and street involvement of patients in emergency departments has been shown to be a barrier to accessing care.^{40, 42} Participants recounted that racism and substance use bias frequently resulted in health care providers overlooking the concerns for which subjects were seeking care, often culminating in early discharges for subjects.

"The fact that [he] was Indigenous and that he was drinking a lot of times, like, got everything else overlooked. And that's why I'm like, if he was begging them to stay, like, who wants to be in the hospital? Nobody wants to be in the hospital, so it's just like, it really bugs me that they were, like, in

the middle of night, like out you go [...] That was the night, that was the night of. So it was after— it was like a few hours after he got discharged that he went to his place and got killed.” — Key Informant

“I don’t know if emergency room doctors have a full grasp of what it is to be homeless. So when they’re giving like ‘do this.’ Like when they’re... what is it called. Discharging them. Like look after yourself in these ways. Well that’s... I can’t keep my foot up or I can’t keep my foot dry or like I can’t take medication at the same day or... like same time every day or even like necessarily hang onto my medication. So I think there’s just a knowledge gap there that often prevents people from getting good care.” — Key Informant

Participants also noted the inadequacy of the medication-based mental health care options available to subjects. Many also highlighted the gap in services available for individuals experiencing concurrent disorders:

“He [Gordon] would get denied service just because of his concurrent disorder, because he was active in his usage so it affected his behavior, so people would be like, ‘Yeah, we can’t— we can’t serve him.’” — Key Informant

“Even if you try to have somebody access services, like the concurrent stuff. In my experience CAMH is not well set up for that. Like ‘oh, they need to be sober for us to do a psych assessment.’ Well, that’s not really an option or unrealistic or even if it is, like lining that up with the appointment [...] or they can’t be psychotic. Like [...] we’re not going to respond to the addictions piece because they’re psychotic. Well, I can’t schedule in a non-psychotic episode break. Like how do you do that? Right? And so then they pass you off between the two, like addictions or... or mental health and... just passes the buck.” — Key Informant

These two participants, speaking about two different subjects, both make it clear that being denied services because of concurrent disorders is a barrier to health. This second quote also exemplifies a commonly articulated need across subjects’ lives: the need for coordination between services.

Barriers to Services and Supports

Subjects were all described as having robust knowledge of the health and social services available to them, often sharing this knowledge with their peers. Subjects also experienced many barriers when accessing services, and when seeking support from family, friends and community.

When accessing services, subjects commonly faced barriers related to their alcohol and substance use, with some participants recounting subjects’ frequent removals from abstinence-based social service agencies and community spaces. Substance and alcohol use was especially noted as a barrier to some subjects participating in ceremony, due both to traditional protocols and agency policies.

For some subjects, unfriendly environments at service agencies and a systemic gap in services for young people who have aged out of youth services were also noted as barriers. Alongside these systemic

impediments to accessing services, a great number of participants articulated the individual barriers to making and keeping appointments that subjects faced due to a lack of stability and coordinated supports:

“Emergency rooms, like health care spaces, if someone’s intoxicated because they’re most abstinence based, it’s like you’re out. But on top of that, if you’re kind of like floating around, if you’re street involved, if you don’t have any kind of stability, like how are you going to remember your appointments. Who’s going to remind you?” — Key Informant

A key recommendation that participants emphasized was coordination between services:

“There’s no way to find out where people are getting supports. There’s no community meeting. There’s nothing [...] and a lot of our folks, it’s like most people can’t do with just one worker. It’s just like, that’s the reality. It’s like, they wouldn’t be homeless in the first place, if all it took was one person to change everything around, like, it doesn’t work like that. It’s because they have multitude of challenges and we keep talking about this Housing First and, like, multi-disciplinary approach, but I find that everything is still fractured. We don’t operate like one organism. So it’s like, it’s great if you have, you know, healthy heart, healthy arm, healthy leg, but if they’re not all pumping on the same system, that’s not a living person. You know? That’s a donation pile.” — Key Informant

“A part of the problem is that the way the roles are set up, everyone is so overly concerned about duplicating services and I understand that, but the reality is that especially when it comes to case management, one case manager can’t carry the weight of entire case for someone if that person is facing multiple challenges. It’s like sure, if someone’s like receiving different types of supports, and everything’s integrated, yeah, then maybe, but that’s usually not the case.” — Key Informant

For many subjects, the combination of discrimination when accessing services and a system that at times actively impedes subjects’ attempts to get care from multiple sources was overwhelming. Fragmentation of services for Indigenous people is a barrier to access noted in the literature,²⁶ and the call for coordination of services expressed by participants is one that has been presented time and time again in research and recommendations regarding Toronto’s Indigenous communities.^{1, 35} Many workers expressed frustration at the systematic barriers in place that hinder their own efforts to coordinate the care of their clients. Often, they recounted forming relationships across agencies with other workers in order to organize systems of care that better met the needs of subjects.

Along with these systemic impediments to accessing support from their families, participants also reflected on subjects’ internal barriers to working through past traumas. The loss of self-worth that accompanied experiences of violence throughout subjects’ lives was noted by many as a hindrance to accessing services, as was the lack of infrastructure for culturally appropriate, no-cost, and non-institutional trauma therapy. Many participants noted that the majority of male subjects simply did not talk about their trauma, and had few avenues to do so.

Criminal Justice System

The criminal justice system was yet another state apparatus that did not serve subjects. All subjects had some level of involvement with the criminal justice system, and key informants described four of five subjects as being frequently in and out of jail for small charges. Incarceration (their own, and the incarceration of friends and family members) was noted as a barrier to giving and receiving support from siblings and street family for some subjects.

“Criminal justice system in itself was just a huge hindrance. Not so much because, like she would get picked up for petty things, like theft unders, or mischief, things like that but her brother going to jail was a huge, took a huge toll on her. Yeah because he... because they stuck together, and he was like, I mean, they supported each other, so I think when he went to jail for such a long period of time, that that was a significant— yeah, that had significant effects on her.” — Key Informant

The long incarceration of Melissa’s brother, who was a key part of her support system, was yet another loss that contributed to the weight of grief she carried. Justin’s loved ones also described how his incarceration impeded not only his ability to receive support from them, but was also detrimental to their well-being since he was an important part of their support systems.

Loss of Self-Worth & Loss of Hope

As mentioned above, the consistent nature of the grief, trauma, and struggle to meet basic needs experienced by subjects had a cumulative effect on their well-being. For those subjects who survived abuse and neglect in childhood, or who were shuffled between many different homes in their youth, this loss of self-worth happened early. One worker described the large number of houses and parental figures through which Melissa was shuffled in her childhood, suggesting that “as a child you internalize a sense of rejection, sense of people not caring, sense of abandonment.” This quote demonstrates the connection between processes of colonial family disruption and the low self-esteem that fuelled cycles of addiction and violence in subjects’ lives.

Many participants described how subjects internalized a sense of rejection and worthlessness after repeated unsuccessful attempts at housing or addictions treatment, and being faced with systemic racism and barriers to essential services.

“If you keep trying to get housing and you can’t afford it or you can’t secure it because when you go to check out places they always say no, or even when you do you get treated horribly. You just... it’s not worth it anymore. Right?” — Key Informant

In addition to the stresses of not having stable housing or reliable income, this quote also alludes to the impact of everyday racism and discrimination subjects faced both on the street and when attempting to access services or housing. One participant spoke about the need for early intervention strategies and resources in the lives of Indigenous youth to prevent individuals from getting to the street:

“There needs to be something [...] to catch kids, help them to learn how to... to learn that they're worth something, worth more than a bottle [...] it's harder once people are here, already on the street because then the trauma just kind of escalates, right? Because they watch each other get hurt and they lose hope and they get hurt again and again.” — Key Informant

The compounded impacts of individual and community-level grief and trauma in the lives of subjects are hard to overstate. Battling with stereotypes and violence from strangers on the street while simultaneously grieving friends and street family members took a heavy toll on subjects, sometimes impeding their ability to stay motivated to make changes in their lives:

“And I’ve noticed over the years, it’s just nobody has any, you know, will to just change because they don’t see the change. They don’t see other people wanting to involve themselves with, you know, their type of people. It’s like they feel like they’re a black cat or something. Walked around and avoid that person, ‘oh, you know, drunk Indian is going to hit us up again for money and yell at us, and blame it on him, or blame it on us’ and whatever, you know.” — Key Informant

Coping

To cope with grief, trauma, and the everyday struggles of street life, subjects used a variety of strategies. Coping strategies included humour, physical activity, being outdoors, and social connection with friends, partners, chosen family and community. Most subjects accessed ceremony as a support, and most used panhandling and ODSP for income.

One participant reflected on John’s use of humour to cope:

“He always used humour to... when dealing with good or bad issues. And it's like... and he was real sarcastic too, like very sarcastic funny. It's like I don’t know, he was just one of kind guy, man, I really, really... I miss the guy still.” — Key Informant

Another participant remarked on how Gordon used involvement in his community as a coping strategy:

“That speak[s to] his social skills, how important community was, being out there, being vibrant, being alive.” — Key Informant

Alcohol & Substance Use

Along with the coping strategies described above, all subjects used also alcohol to cope, with three subjects regularly using other substances as well. Many key informants described subjects turning to alcohol and substances to cope when no other respite was available, a habit compounded by subjects not having the opportunity to learn healthy coping skills from their families.

Speaking about Justin’s use of alcohol to cope, one friend had this to say:

“It’s just his upbringing and like, he went through a rough life, like, I don’t think... his mom loved him but she didn’t love him, and I know that goes a long way. And his dad really didn’t, like wasn’t in his life. Being in and out of jail, and even going through foster care and stuff like that, that’ll take a lot of... that’ll take a lot of you, you know what I mean, especially if you don’t know how to deal with it properly. Yeah, just... just doesn’t know how to deal with things, like, you know what I mean?” — Key Informant

This quote typifies the relationship between child apprehension, intergenerational trauma and the resultant lack of coping skills passed through families, and the subsequent dependence on alcohol and substances that was common among subjects.

Similarly, one service provider reflected on the impact that grief and trauma had on Melissa’s use of substances to cope:

“Similar experience in [my] generation is just how common it is to have peers in your teens and early 20s who have committed suicide and just the emotional and the impact on you. Never mind all the other kind of... right. You have to... that’s just a lot to deal with. And I would assume that would contribute to kind of the need for substances and... so I don’t know if that’s a need for, I don’t know, emotional respite or stability or... I don’t know what you call that. Break from trauma.” — Key Informant

Another service provider suggested that Melissa would have benefitted from counseling or trauma therapy at a young age in order to provide her with coping strategies other than alcohol:

“If she had access to some sort of counseling like, younger, a lot of this stuff could have been prevented, because she would have maybe have had more tools to cope with some things, or at least even know where to start. Yeah. And so I think her drinking was such a symptom of just like other things that were going on. So I know, sometimes I’m like, ‘Oh yeah, addiction counseling would be great,’ and I’m like, actually I kind of feel like other stuff if they were dealt with and perhaps the addiction actually not even be as huge of a deal, right?” — Key Informant

These addiction challenges often had significant impacts on the quality of care subjects received from the health care system, particularly in Emergency Departments. In some cases, alcohol and substance use also interfered with subjects’ access to their children or nieces and nephews, or prevented subjects from accessing cultural supports and ceremony, thereby further removing them from the networks of support whose precarity impacted their turn to substances in the first place. Further, for three of five subjects substance use was either the cause of death (as in two overdose cases) or directly linked to the cause of death (as in the case of liver failure). Most subjects had accessed addictions treatment at various times in their lives, with many participants highlighting the need for non-abstinence based addictions supports, as well as addictions supports that were designed specifically for Indigenous people.



Robert had struggled with his alcohol addiction for many years, and also used street drugs. His alcohol use interfered with his ability to retain housing and employment as well as his ability to see his young son. With the rise in violence in the street community and the deaths of several friends as fentanyl made its way onto the streets, workers noticed he was markedly more

irritable and more sad than usual, and also noted an increase in his substance use and alcohol use. One worker described how his coping skills of humour and socializing had been put to the test by the shock and grief of the increase in fatal overdoses within his community. On the night he died, Robert had been using alone, and was found unresponsive in a downtown park.

Robert's death is one of an increasing number of drug-related deaths among Toronto's homeless population over the past several years. A 2018 report by Ontario's Office of the Chief Coroner confirmed that drug toxicity is a leading cause among recent Toronto homeless deaths; further, in these cases of death by drug toxicity, over 80% involved fentanyl.⁴³ The recently released Toronto Indigenous Overdose Strategy⁴⁴ also makes strong links between the trauma of losing friends and peers to overdose and increased levels of substance use. Together, these data suggest an urgent need for intervention both into the current overdose crisis and the grief left in its wake.

Dreams, Desires & Motivation

All five subjects had unique dreams, desires & goals, and were motivated by a variety of factors in fulfilling them. Justin was motivated by his love for his daughter & his desire to provide for her; Gordon was driven by a need for community and thirst for knowledge; Melissa had a keen desire for justice and safety for herself and her street family, while also dreaming of things that many young people strive towards:

"She would sometimes talk about wanting to get a place, make her place nice. She would talk about just like wanting to work with youth, you know, she loved kids, was really good with kids. She had talked about wanting to be there for her nephews you know, that they would you know, have fun Auntie [Melissa] to be around. I think she also would just see other people... I remember distinctly one time we were just outside McDonald's and like we're sort of in the U of T area, so we kind of just noted that there were people across the street that looked like us, right? Young females, just kind of doing their thing, but they were students, and she was like, 'I could do that too.' And I was like, 'Yeah, you totally could.'" — Key Informant

Many of Melissa's dreams — to have a safe and stable home, and to be present in the life of her family — were shared by all subjects. As noted in the above discussion of family disruption, many subjects were driven by a thirst for belonging and a supportive family structure. For Gordon, this desire to be with his community also compounded his addiction challenges, when he sought out peers with whom to connect and did so by drinking:

"[Gordon] really, you know, I think he did... it was neat that he did have, like, hopes and dreams and he, he did have sober times where he did try to chase them. But it was like, I don't know, he would just get, I don't know, feel disconnected somehow and then just connect with people that brought him the other way to where he was just drinking with them and whatever, and then I would see him off by himself and finding— trying to find people to hang with." — Key Informant

Due to the realities of street life and the supports available to subjects, most dreams and goals were put on the backburner while everyday survival was top priority. Many participants noted the difficulties that the everyday strain and uncertainty of street life posed to subjects' reaching their goals:

"It was hard, I think, sometimes for her [Melissa]... to keep dreaming, to keep believing that she would get anywhere else or to even start to put those plans in place. Like she would talk about wanting to get housing, wanting to do this and wanting to do this and then she would drop because she forgot it was Monday. Or she was hungry and went somewhere and it was warm and she ate and she fell asleep, you know, those kinds of things, right? Like they're just... it's hard to... yeah, it's hard to get any traction when you're just surviving." — Key Informant

Mutual Networks of Support

"What I've learned to understand, through working with our community, especially that group, it's like they consider each other home." — Key Informant

Community was an important source of strength and support for all subjects; likewise, all subjects contributed to their communities in a variety of ways, from Gordon's consistent involvement at his local community centre to Justin's work supporting fellow youth. Because they played support roles in the lives of other community members, each subject's death leaves a gap in these reciprocal support relationships. Key informants noted that subjects' street family, service providers and community often don't want to know details of how subjects died, in part because of the high number of recent community deaths.

Many service providers relayed stories about the profound impact that subjects had on their lives. One service provider shared a story about a particularly treasured moment she spent with Gordon while hurrying to an appointment:

"We would be walking down and here's us battling with our two ways of moving through the world and he wants to stop and sit on his rollator and feel the sun and I'm going like this. And us mutually trying to agree upon some way to get there while honouring each other's ways of being was so interesting. And he looked at me one day, and he wasn't always very clear, but he was clear, clear, clear, and he said '[name], you spread yourself too thin. Stop and feel the sun.' And that's life changing." — Key Informant

Just as Gordon received support from this service provider, so too was she impacted by the provider-client relationship the two shared. Many participants also highlighted the importance of honouring each subject as an individual person who had strengths and challenges, and contributed to their community:

"I'm glad at least some of the stories got out, because I think it's really important for the wider society to think of our folks as individuals. I don't call them clients. They're not clients. I mean, I know they use services, but they are community members, like, we belong to the same community. And it's just like

we're here, our job is to support them. And it's like, they're people, they're not 'the homeless.' They're not, like, 'social service user.' They're— they're people.” — Key Informant

What's Working

Amidst reflections on the barriers and service gaps experienced by subjects, participants also identified the supports and services that were working for subjects and their communities. For two subjects, being housed in close proximity to the services they regularly used helped them retain their housing. A great number of participants identified the building of trusting relationships between service providers and clients as key for successful service provision; many noted that building these relationships takes time and resources, which are too often constrained by agency policies and budgets.

“The thing with her [Melissa] I noticed that trust was a big thing, understandably so, I think our trust developed because of just the consistency of presence.” — Key Informant

“People who give us money, they don't understand how long it takes to gain someone's trust. It takes working with someone a long time to get them to tell you things, and as I said, I intentionally don't probe and that's why I didn't even ask what the exact circumstances of his death were, unless I'm personally dealing with it directly [...] It's like you need to access any type of service, you have to tell your life story. So I really like, when working with people I try to let them at least have that on their terms. It's like no, you tell me what you need to tell when you feel like telling it.” — Key Informant

In these two participants' experiences, building trusting relationships with clients through a non-invasive approach is a practice that takes time but yields results.

Another service that key informants recognized as successfully meeting the needs of subjects was non-judgmental and harm-reduction based street outreach:

“At no point does any services actually get down to the level that people need it, which is actually coming to where we are. Right? We're there. [...] [Melissa] needed someone to go meet her in a park and to talk to her and be there and not ask her any questions or anything for a little bit. Maybe subtly but that's it for some time. It takes time to gain those relationships with people, right?” — Key Informant

Taking the time to build relationships with clients as community members, literally meeting them where they are at, and offering non-judgmental support were key aspects of successful street outreach identified by participants.

“[Justin] really liked Vern Harper coming out, and every time he'd see him he'd sit there and talk with him and like you know. Just even talking to somebody so spiritual like that. It kind of makes you think, like think more, like I could do more. I can do more, and then, other than sit in this park and drink, right. And that's what... like I think we need more outreach workers that are not so judgmental.” — Key Informant

As this participant describes, Justin benefitted substantially from the non-judgmental, harm reduction-based outreach provided by this community Elder. Accessing traditional teachings, even while actively using alcohol and substances, was an important support in the life of this subject and his peers.

Discussion & Conclusion

Throughout their lives, these five subjects demonstrated remarkable strength, resilience, and tenacity. All five coped with systemic discrimination and barriers to accessing services using humour, strength of spirit, and connection to their communities, but were also impeded from accessing some positive coping strategies by abstinence-based services and targeting of Indigenous families by child welfare agencies. Each subject contributed to reciprocal relationships of support in their communities, and they are all deeply missed. Although the causes of death for subjects were wide-ranging, the circumstances contributing to these direct causes are attributable in large measure to the ongoing impacts of colonization.

Many of the factors leading to the premature deaths of these five community members can be traced back to their separation from their families at the hands of child welfare organizations. Because subjects did not have the opportunity to learn positive coping skills and develop a strong sense of self-worth from their families, they instead coped using methods that jeopardized their housing and their health, and in three cases were directly related to the causes of their deaths. The experiences of subjects are corroborated by other research demonstrating strong links between experiences of foster care and experiences of homelessness among Indigenous people in Toronto,^{1, 31} as well as connections between early trauma and/or dislocation from family and community and coping through alcohol and substance use.^{3, 20, 26, 32, 44} Importantly, the cyclical nature of child apprehensions and passage of intergenerational trauma between parents and children is also well-established in the literature,^{20, 28, 30} pointing to the harsh reality that without intervention both to reduce the number of apprehensions taking place and to provide healing to those adults who were apprehended as children, deaths like those experienced by our subjects will likely continue. Given these realities, preventing the separation of Indigenous children from their families is of utmost importance in preventing premature deaths among Indigenous people.

Another key area for preventing future deaths is through coordination of health and social service provision. When subjects tried to access health care, social services, and housing supports, they were faced with a fragmented system of uncoordinated supports that was extremely difficult to navigate. Indeed, as demonstrated by the repeated accounts of violence and harassment from police, and experiences of racism and inadequate care in hospitals, subjects were oftentimes harmed by the very institutions purportedly meant to serve them. Once again, these realities are corroborated in the literature.^{1, 4, 18, 39-42} For many subjects, the support services that worked best were those which took a harm reduction approach to substance use and provided time for workers to build relationships with community members; however, such supports were necessarily limited by the operational constraints of social service agencies. With limited options for affordable and safe housing, subjects relied on themselves and their chosen families to meet their needs for shelter and safety, forming strong

networks of mutual care and support where their presence is missed. In the face of scarce access to culturally appropriate and ceremonial supports to work through complex grief and trauma, subjects coped using alcohol and other substances. This coping strategy, in turn, was a further barrier to accessing services, and obtaining and retaining housing, and as noted above, was a contributing factor in multiple subjects' deaths.

The deeply interconnected facets of ongoing colonial trauma, high demand on limited-capacity services, and limited access to traditional cultural and ceremonial supports must be addressed both through services and through policy. Effective implementation of the recommendations presented in this report will require coordination and cooperation between multiple levels of government and many health and social service agencies. The deaths of these five community members were preventable, and given the strong links between the policies of the Canadian government and the contextual factors leading to their deaths, the burden of mitigating the effects of these policies should fall on the body that wrote and enforced them.

Limitations

There are some limitations to this study. The sample size was small, and may not be representational of all of the contextual factors and causes surrounding premature deaths of Indigenous homeless people in Toronto. As well, none of the subjects were identified by key informants as being as LGBTQ or two-spirit, meaning that this analysis does not account for those unique factors which may contribute to premature deaths of Indigenous community members who have diverse sexualities or genders. As only one subject was a woman, the study also may not capture those factors specifically contributing to the premature and preventable deaths of Indigenous women on Toronto's streets. An original proposed subject of this study was replaced because their primary connection was to a social service agency unable to participate in this study. Subjects who remained in the study were all connected to more than one health or social service agency. This report acknowledges that this sample of community members does not include those whose connections to health and social service providers were limited.

Recommendations

Recommendations that would have helped to prevent the deaths of these five subjects have been presented to policy-makers time and time again, and have consistently been neglected. The work required to transform the systems that led to these deaths cannot be captured through a brief list of recommendations here. However, key informants laid clear directions for first steps in implementing the system-wide change that is so deeply needed; we present these recommendations in acknowledgement that we are not the first (and likely will not be the last) to offer them.

1. Dramatically reduce child apprehension

In accordance with Calls to Action numbers 1-5 of the Truth and Reconciliation Commission of Canada (2015), it is recommended that all levels of government work to reduce the number of Indigenous

children in care through providing adequate funding for initiatives that keep families together, including strength-based practices such as Indigenous midwifery. This recommendation follows many calls for overhauling Indigenous child welfare systems across Canada through investment in Indigenous communities, dating back to the Report of the Royal Commission on Aboriginal Peoples (1996) and beyond.^{19, 20, 28, 45, 46}

2. Address community-level grief

Ensure a range of opportunities for addressing historical, intergenerational, childhood and ongoing trauma and grief for Indigenous communities. Heavily resource:

- Culturally safe, no-cost trauma counseling in non-institutional settings.
- Culturally safe, no-cost grief supports in non-institutional settings.
- Access to traditional cultural supports for trauma and grief for clients, service providers, and the broader Indigenous community. This includes increasing access to Elders, traditional teachings and ceremony for community members who are using substances.

3. Provide housing that is safe

One hundred per cent of people who need housing should be offered housing that meets their needs, whether that be:

- Supportive housing that includes 24-hour staffing, counseling, assistance managing appointments and medication, and assistance transitioning from street life;
- An Indigenous specific harm reduction shelter;
or
- Deeply affordable and permanent housing.

Ensure that all housing:

- Allows people to maintain their physical safety.
- Is clean and in decent repair.
- Offers privacy and peace.
- Is culturally supportive – for example, includes access to Elders and freedom to smudge.
- Is responsive to the needs of community members who are using substances and includes a mix of abstinence-based and harm reduction approaches.

4. Address racism and discrimination in Emergency Departments

There is an urgent need to put in place comprehensive plans to address the racism and discrimination in Toronto's Emergency Departments. Some initial steps should include:

- Accountability mechanisms related to racism and discrimination such as a formal complaint process with actionable consequences.

- 24/7 Indigenous patient advocates and culturally appropriate supports in EDs that are embedded in all aspects of ED care.
- Community-led, mandatory education for all health care practitioners and all Emergency Department staff on cultural safety, anti-racism, and treating street-involved patients.
- Discharge practices that take into account patient circumstances and ensure that people can maintain their physical safety once they leave the ED.

5. Address gaps in the mental health system

- Ensure that people with mental health problems aren't treated only with medication, and that people are not coerced into accepting treatment.
- Ensure that culturally safe trauma counseling and culturally appropriate supports are always available and offered. A wide variety of non-medication options for mental health care must be made available to all Indigenous community members.
- Ensure intake processes and services are appropriate for and accessible to people experiencing concurrent disorders.

6. Care for community members who are using substances

It is vital that the Toronto Indigenous Overdose Strategy⁴⁴ be implemented immediately. Recommendations from the strategy mirrored in our findings include providing:

- Addiction services specifically developed for Indigenous peoples.
- Addiction services outside of an abstinence-based model.
- Education about fentanyl and naloxone, and access to naloxone, for people who are using substances, and their friends, families, and communities.
- Increased access to safe injection sites.
- Harm reduction frameworks accompanied by robust supports so as to not generate increased risk.

7. Resource the grassroots prevention work that community members are already taking on

Our findings surfaced impactful, grassroots efforts that offer support to Indigenous community members experiencing homelessness. These include:

- Non-judgmental, harm reduction-based outreach provided by community Elders.
- A group of people in the community that coordinates to offer support and resources where needed. For example, accompanying people to court, advocating for housing and care, linking community members with organizations, accompanying people to appointments and much more.

8. Resource service providers to offer responsive, non-stigmatizing services

- Ensure providers such as case coordinators have the time, space and mandates to establish long-term, trusting relationships with clients.

- Worry less about duplication of services, and more about quality of relationships, and coverage of needs. Some people could use more than one case coordinator, and in these cases, workers should be offered the time and resources to collaborate with each other across organizations.
- Literally meet clients where they are at with non-judgmental outreach services, and meaningfully integrate client recommendations into services and policy.

9. Provide care during the transition from youth into adult service users

- Extend or create Indigenous community-led services and programs for youth ageing out of care. Such programs and services must address holistic health, housing, employment, education and cultural needs, and could include initiatives such as designated transition workers in the shelter system, and peer mentorship opportunities for youth.

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